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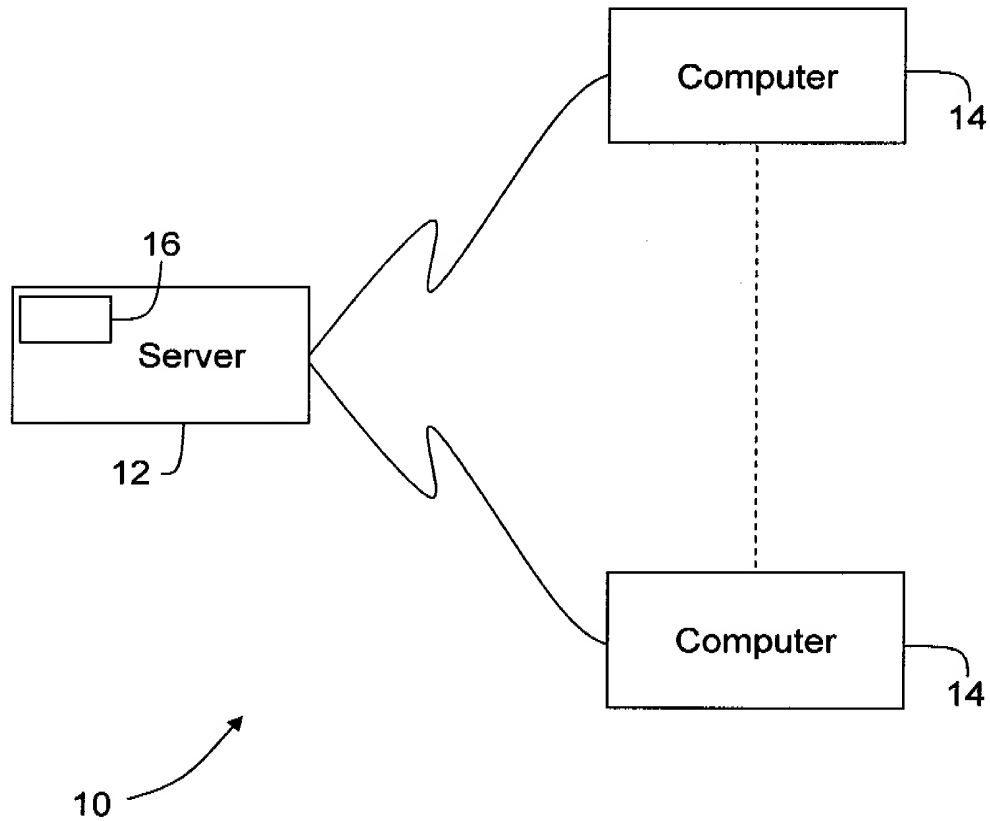


FIG. 1

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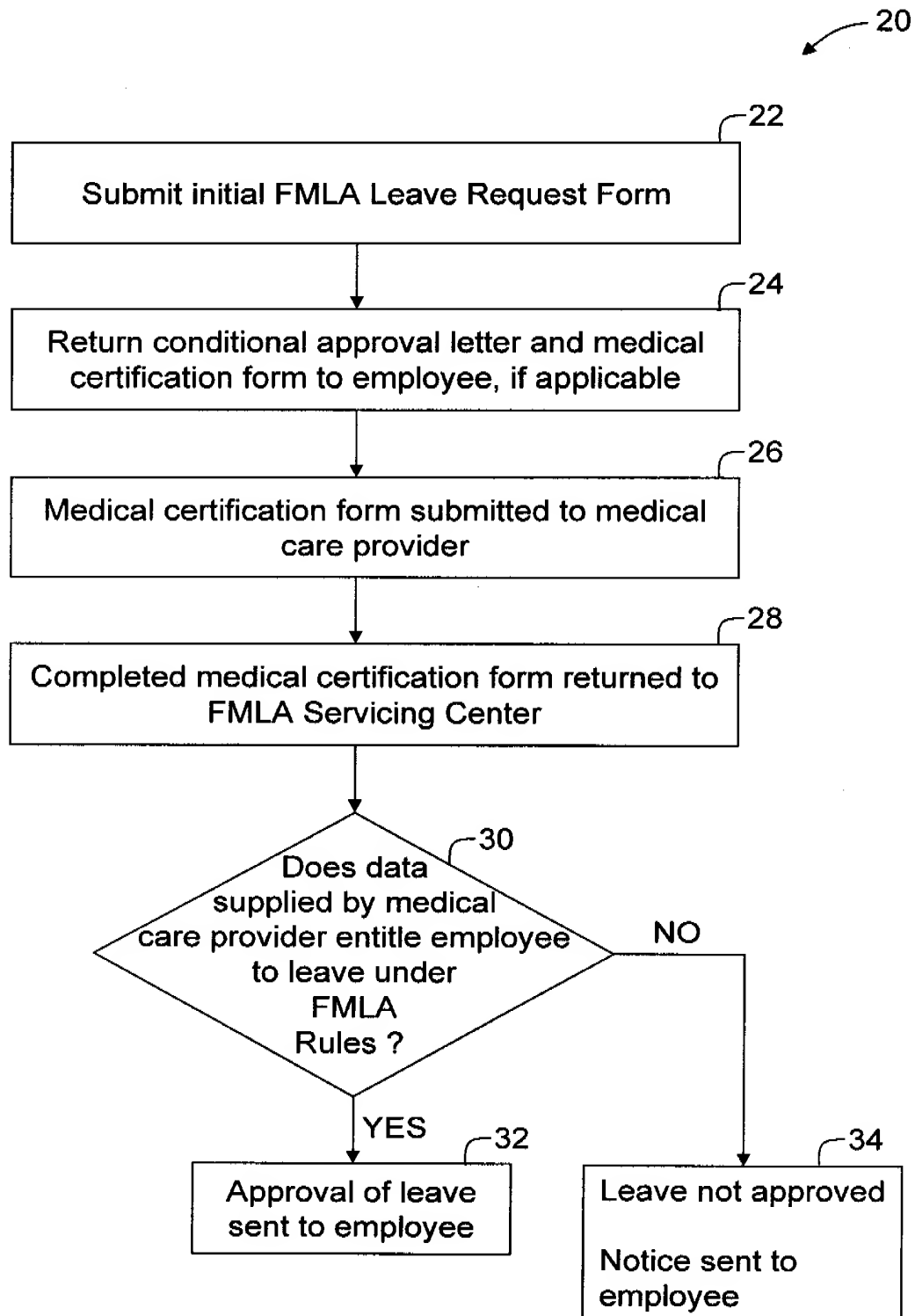


FIG. 2

- REPLACEMENT SHEET -

Title: SYSTEMS AND METHODS FOR TRACKING EMPLOYEE LEAVES UNDER THE FMLA
 Inventor(s): Rachel S. Lieberman et al. Application No.: 09/752,274 Attorney Docket No.: 60709-00019
 Attorney: Daniel M. Fitzgerald; Phone: (314) 621-5070

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Initial FMLA Leave Request Form

Any incomplete information will delay the processing of this request

If you have any questions, please call the FMLA Center toll free at 877-555-FMLA/(877)-555-3652

1 Form submitted by: 86 88 66
If different from employee

Employee Name: John Smith GE Capital Business
SS No: 123-45-6789

Home address: 58 64
(Street) (City) (State) (Zip)

Home Phone: 60 70 MGR: 74 HR Rep.: 64
(mm/dd/yy)

Date of Hire: 62 72 MGR phone: 76 HR Rep. phone: 82

Work Location: 68 Current Work Schedule:
(City/State) (Days/Hours per week)

Work phone: 78 84 ☐ Check this box if you are applying for disability benefits
(note: you must call the disability center to apply for disability benefits)

2 Reason for Leave

Please check (✓) the reason for the leave you are requesting

HOSPITAL

PREGNANCY

NEW CHILD

PERSONAL MEDICAL CONDITION

FAMILY

☐ Inpatient hospital stay, recovery from stay or treatment related to stay. 90

☐ Incapacity due to pregnancy and prenatal care (before the child is born). 92
Expected delivery date: 104

☐ Time to care for a newborn child or a newly placed adopted or foster care child (for moms and dads). 94

☐ Too sick to work for more than three consecutive days (including non-work days), and saw a health care provider twice; 96

☐ Too sick to work for more than three consecutive days (including non-work days), and saw a health care provider once and given a continuing regimen of treatment (e.g., therapy, medication); 98

☐ Incapacitated by or out to receive treatment for a serious chronic or permanent health condition (e.g., asthma, diabetes, cancer). 100

☐ To take care of/provide support for a sick eligible family member who falls into one of the categories above (except care of a new child). 102

106

3 Type of Leave

Please check (✓) the type of leave you are requesting

☐ **108 Full, Continuous Leave**
 Requested time period:
 Begin date: 110 to 112 end date
(mm/dd/yy) (mm/dd/yy)

☐ **114 Reduced Schedule**
 Requested reduced work schedule:
116 hrs./day
118 hrs./week
120 days/week

Time period for which you are requesting the reduced schedule:
 Begin date: 122 to 124 end date
(mm/dd/yy) (mm/dd/yy)

☐ **126 Intermittent Leave** (i.e., occasional, episodic)
 If the medical condition is occasional or episodic, we require a specific time period for coverage under the FMLA (up to 1 year maximum)
 Begin date: 128 to 130 end date
(mm/dd/yy) (mm/dd/yy)

(Name of family member & relationship to you)

FIG. 3

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	1	2	3
Medical Certification for FMLA - Employee Take this form to your medical provider for certification. For questions regarding this form call 877-555-FMLA/877-555-3652, Return to the FMLA Center by _____			
Name:	John Smith		SS No.: 123-45-6789
1 Reason for Leave - Medical Provider must check (✓) any and all that apply.			
PREGNANCY - I certify that the above patient is/has been/will be:			
142	<input type="checkbox"/> Incapacitated* due to pregnancy. <input type="checkbox"/> Receiving prenatal care.- Expected delivery date: _____		
MEDICAL CONDITION - I certify that the above patient is/has been/will be:			
<input type="checkbox"/> Incapacitated* for more than 3 consecutive days and received treatment at least 2 times for this condition.			
<input type="checkbox"/> Incapacitated* for more than 3 consecutive days and received treatment for this condition and prescribed a regimen of continuing treatment (i.e. therapy, Rx).			
<input type="checkbox"/> Incapacitated* by or out of work to receive treatment for a chronic serious health condition which 1) requires periodic visits/treatment and 2) continues over extended period of time and 3) causes episodic or continuing incapacity*.			
<input type="checkbox"/> Incapacitated* by a permanent/long-term condition for which patient is undergoing continuing treatment (i.e. Alzheimer's, severe stroke).			
<input type="checkbox"/> Out of work to undergo examination/testing for a condition that would likely fall into one of the categories listed above or require inpatient stay.			
* Unable to work or perform regular daily activities.			
HOSPITAL STAY - I certify that the above patient is/has been/will be:			
<input type="checkbox"/> Inpatient in a hospital, hospice, or residential medical care facility.			
<input type="checkbox"/> Out of work to receive treatment for a condition connected to previous inpatient stay.			
<input type="checkbox"/> Recovering from inpatient stay and incapacitated (unable to work or perform regular daily activities).			
2 Dates/Time of Leave - Medical Provider must indicate dates and times of leave			
Continuous Leave: (If Requested) - I certify that the above patient has a medical need for leave as described.			
144	Requested time period - Begin date: _____ to _____ end date (mm/dd/yy) (mm/dd/yy)		
Reduced Hours: (If Requested) - I certify that the above patient has a medical need for leave as described.			
Requested reduced hours schedule _____ hrs./day _____ hrs./week _____ days/week			
Requested time period - Begin date: _____ to _____ end date (mm/dd/yy) (mm/dd/yy)			
Intermittent (i.e., occasional, episodic) Leave: (If Requested) - I certify that the above patient has a medical need for leave as described.			
146	Requested intermittent schedule _____ hrs./day _____ hrs./week _____ days/week		
Indicate approximate duration of medical condition - Begin date: _____ to _____ end date (mm/dd/yy) (mm/dd/yy)			
3 Signature Stamp - Medical provider must sign and return form to the FMLA Center			
Medical Provider Signature: _____ Phone: _____ Fax: _____			
Print Name: _____ Type of Practice: _____			
Address: _____ (city) (state) (zip)			

FIG. 4

- REPLACEMENT SHEET -

Title: SYSTEMS AND METHODS FOR TRACKING EMPLOYEE LEAVES UNDER THE FMLA
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①	②	③
Medical Certification for FMLA - Family Member Take this form to your family member's medical provider for certification. For questions regarding this form call 877-555-FMLA/877-555-3652. Return to the FMLA Center by _____		
142 Patient Name: <u>John Smith</u>	172 Relationship to Employee: <u>SPOUSE</u>	174
Employee Name: <u>Janice Doe</u>	148 SS No.: <u>123-45-6789</u>	150
① Reason for Leave - Medical Provider must check (✓) any and all that apply.		
PREGNANCY - I certify that the above patient is/has been/will be: <input type="checkbox"/> Incapacitated* due to pregnancy. <input type="checkbox"/> Receiving prenatal care.- Expected delivery date: _____		
MEDICAL CONDITION - I certify that the above patient is/has been/will be: <input type="checkbox"/> Incapacitated* for more than 3 consecutive days and received treatment at least 2 times for this condition. <input type="checkbox"/> Incapacitated* for more than 3 consecutive days and received treatment for this condition and prescribed a regimen of continuing treatment (i.e. therapy, Rx). <input type="checkbox"/> Incapacitated* by or out of work to receive treatment for a chronic serious health condition which 1) requires periodic visits/treatment and 2) continues over extended period of time and 3) causes episodic or continuing incapacity*. <input type="checkbox"/> Incapacitated* by a permanent/long-term condition for which patient is undergoing continuing treatment (i.e. Alzheimer's, severe stroke). <input type="checkbox"/> Out of work to undergo examination/testing for a condition that would likely fall into one of the categories listed above or require inpatient stay. * Unable to work or perform regular daily activities.		
HOSPITAL STAY - I certify that the above patient is/has been/will be: <input type="checkbox"/> Inpatient in a hospital, hospice, or residential medical care facility. 144 <input type="checkbox"/> Out of work to receive treatment for a condition connected to previous inpatient stay. <input type="checkbox"/> Recovering from inpatient stay and incapacitated (unable to work or perform regular daily activities).		
② Dates/Time of Leave - Medical Provider must indicate dates and times of leave for the employee		
Continuous Leave: (If Requested) - I certify that the above employee is needed to care for, or provide beneficial psychological comfort to spouse, child (who is under 18 or incapable of self-care), or parent for the following time period: Requested time period - Begin date: _____ to _____ end date (mm/dd/yy) (mm/dd/yy)		
Reduced Hours: (If Requested) - I certify that the above employee needs reduced work hours to take care for, or provide beneficial psychological comfort to spouse, child (who is under 18 or incapable of self-care), or parent for the following time period: Requested reduced hours schedule _____ hrs./day _____ hrs./week _____ days/week Requested time period - Begin date: _____ to _____ end date (mm/dd/yy) (mm/dd/yy)		
Intermittent (i.e., occasional, episodic) Leave: (If Requested) - I certify that the above employee needs intermittent leave to care for, or provide beneficial psychological comfort to spouse, child (who is under 18 or incapable of self-care), or parent for the following time period: 146 Requested intermittent schedule _____ hrs./day _____ hrs./week _____ days/week Indicate approximate duration of medical condition - Begin date: _____ to _____ end date (mm/dd/yy) (mm/dd/yy)		
③ Signature Stamp - Medical provider must sign and return form to the FMLA Center		
Medical Provider Signature: _____	152 Phone: _____	154 Fax: _____
Print Name: _____	158 Type of Practice: _____	160 (field of specialty, if any)
Address: _____	162 (city)	(state) (zip)

FIG. 5